



**CONFIDENTIAL NEW PATIENT INFORMATION FORM**

203 Elden Street Suite #301  
Herndon, VA 20170  
PHONE: (703)464-5597 FAX: (703)955-7838

**Patient Details**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

Birth Date: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_/\_\_\_/\_\_\_

Address:

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email Address:

Employer Name:

Type of Work Performed:

Name of Spouse (parent, if you are a minor): \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US?

**Visit Details**

Chief Complaint:

Date Problem Started: \_\_\_\_\_ Auto Accident Related:  Yes  No Work Related:  Yes  No

Do you have a pacemaker? Yes  No

Other Secondary Problems or other Health Problems?  Yes  No Explain: \_\_\_\_\_

Do you suspect that you may be pregnant?  Yes  No

Are you currently taking any over the counter medications?  Yes  No Explain: \_\_\_\_\_

Are you currently taking medications for the following: Anti-inflammatory  Muscle Relaxants  Birth Control

Blood Thinners  High Blood Pressure  Pain Relievers

Other  Explain: \_\_\_\_\_

Have you ever been diagnosed with: High Blood Pressure  Heart Attack  Emphysema  Seizures/Convulsions

Thyroid Disease  HIV  TB  Circulation Problems  Cancer  (If yes, please describe type of cancer): \_\_\_\_\_

Previous Chiropractic Care  Yes  No Doctor: \_\_\_\_\_

Please note: payment or insurance co-payment is expected at time of visit.

I understand that my care in this office may involve the making of judgments that are based upon the facts known by the doctor. Therefore, the above information is true and complete to the best of my knowledge. I also understand that the practice of any healing art is not an exact science and that no guarantee of results will be made by the doctor nor relied upon me. I further understand that the doctor's professional expertise lies in detecting and correcting structural and mechanical aberrations of the spine. I agree that he will not be held responsible for the diagnosis or treatment of any medical condition indicated above.

Patient Signature

Date



**CONFIDENTIAL NEW PATIENT INFORMATION FORM**

203 Elden Street Suite #301  
Herndon, VA 20170  
PHONE: (703)464-5597 FAX: (703)955-7838

**CHIROPRACTIC AUTHORIZATION RELEASE & EXPLANATION**

**CONSENT FOR CHIROPRACTIC TREATMENT**

I hereby request and authorize Dr. Devinder P. Singh, D.C. at Spine and Laser Center to perform diagnostic tests and render chiropractic adjustments and other treatment. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**

I Authorize Payment of Any Medical Benefits from \_\_\_\_\_ to be Paid Directly to This Chiropractic Clinic for Any Service Rendered to Me.

**AUTHORIZATION AND ASSIGNMENT**

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payments to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to have been made to collect sums due for the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies' proceeds, whether it be all or part of what is due, I personally owe you.
4. I hereby waive the statute of limitations on collection regarding my case and care.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed are paid in full.

**MEDICAL RECORDS RELEASE AUTHORIZATION**

I, \_\_\_\_\_, do hereby authorize the Spine and Laser Center/Dr. Devinder Singh, to obtain any and all medical records deemed necessary for my treatment at the above referenced facilities. This authorization includes but is not limited to: X-rays, MRI's, any diagnostic imaging results reports, medical history forms, physician reports, urgent care medical records, laboratory results, and any other medical records requested by the Spine and Laser Center/Dr. Devinder Singh. Excluded in this authorization are any psychological or psychiatric records and any medical records that pertain to the mental health of my person.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



**CONFIDENTIAL NEW PATIENT INFORMATION FORM**

203 Elden Street Suite #301  
Herndon, VA 20170  
PHONE: (703)464-5597 FAX: (703)955-7838

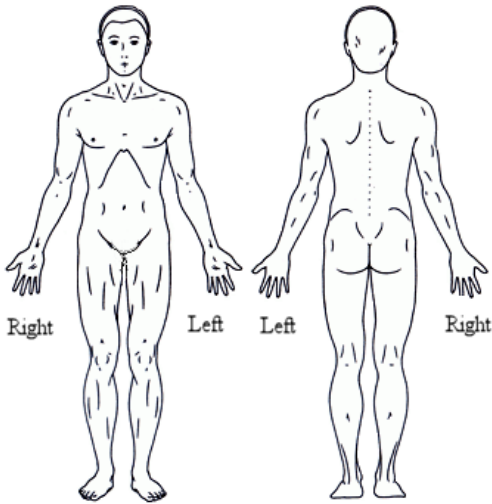
Have you had similar problems/injuries/complaints before? Yes  No

If yes, explain: \_\_\_\_\_

Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.



Numbness = = =

Dull Ache OOO

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other \_\_\_\_\_ ^ ^ ^

Is your pain: Constant  Intermittent

If your pain is intermittent, how often and how long does it last? \_\_\_\_\_

Does the pain radiate to your arms or legs? \_\_\_\_\_

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is this condition worse during certain times of the day? Yes  No  If Yes, explain \_\_\_\_\_

Is this condition interfering with Work  Sleep  Daily Routine  Other  \_\_\_\_\_

Is this condition progressively getting worse? Yes  No

History of car accidents? Yes  No  If Yes, explain: \_\_\_\_\_

Major Surgeries/Operations? Yes  No  Explain: \_\_\_\_\_

Previous Fractures or Broken Bones? Yes  No  \_\_\_\_\_

Do you have frequent Headaches? Yes  No  If yes, how often? \_\_\_\_\_

Do you have any foot/ankle/knee pain? \_\_\_\_\_

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Print Name \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_